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Care Services Data

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Sexually Transmitted Disease (STD) Data

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Behavioral Risk Factor Survey System (BRFSS) Data

Health Status of Rural and Ethnic Minorities in Nebraska

Eliminating Racial and Ethnic Disparities in the STD Program

STD Screening for Females Receiving Pregnancy Tests in Reproductive Health Facilities

Indirect Indicators of Risk for HIV/AIDS Infection in Nebraska

SUPPLEMENTAL DATA

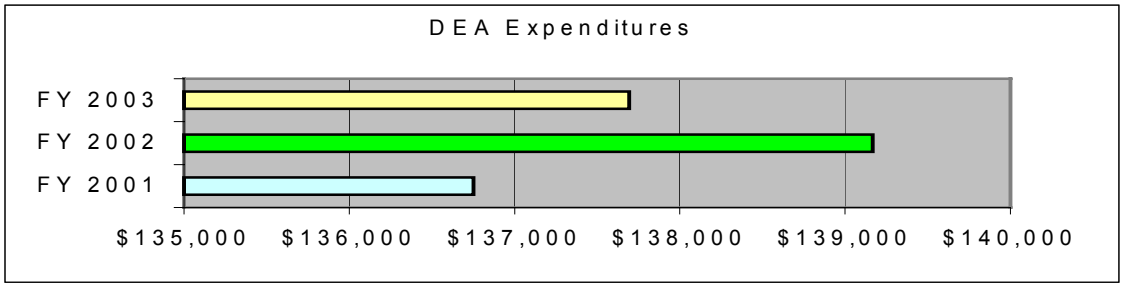
During 1999 - 2003, several supplemental data assessments were completed, including CARE Services, Hepatitis, STDs, YRBS, BFRSS, and Minority Health.

CARE SERVICES DATA

In FY 2003 (April 1, 2003-March 31, 2004), the Ryan White Title II Program provided case management and direct emergency assistance (housing, utilities, transportation, health insurance, and food assistance) to 424 unduplicated clients[1]. Males represented 72% and females represented 28% of clients served. 57% of clients served were white, 26% were black, and 17% identifying as Hispanic or other. The majority of clients served (66%) were between 25-44 years of age. Clients over 45 years of age represented 29%, with clients 20-24 representing 4% of clients served.

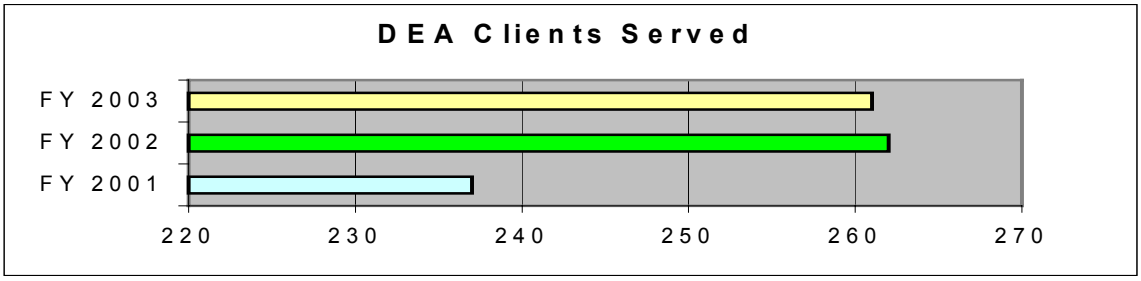
In FY 2003, $137,696 in Title II funding provided direct emergency assistance to 261 clients. The majority of funding (69%) provided housing assistance to clients. The remainder of funding was utilized for utility assistance (21%), transportation (5%), food (1%), and insurance premium payment assistance (1%)[2].

The following chart shows the three-year trend in direct emergency assistance:



Funding for Direct Emergency assistance has been relatively flat during the past three years. The following chart shows the number of clients receiving direct emergency assistance during this same period.

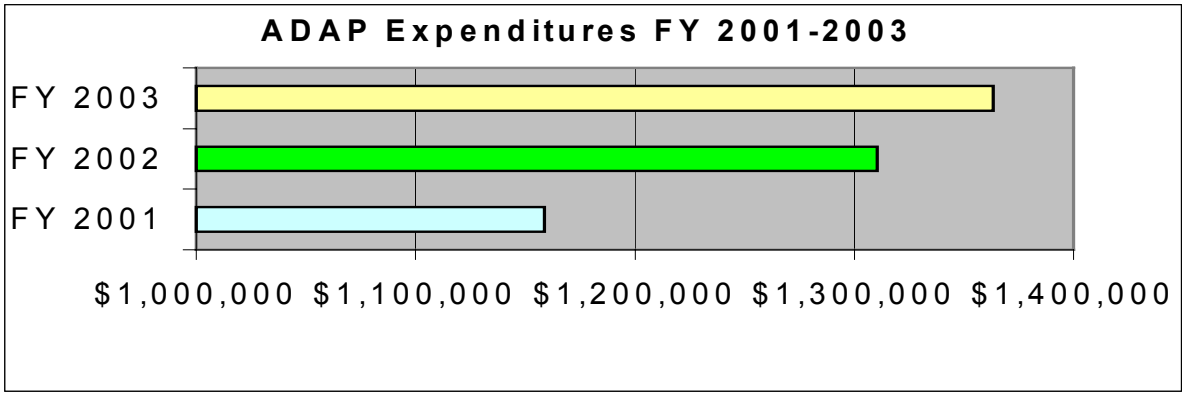
[1] Total includes all clients receiving at least one case management visit. Direct Emergency Assistance was provided to a portion of total clients reported.
[2] 3% of direct emergency assistance was utilized for administrative fees for check writing services and transportation assistance.

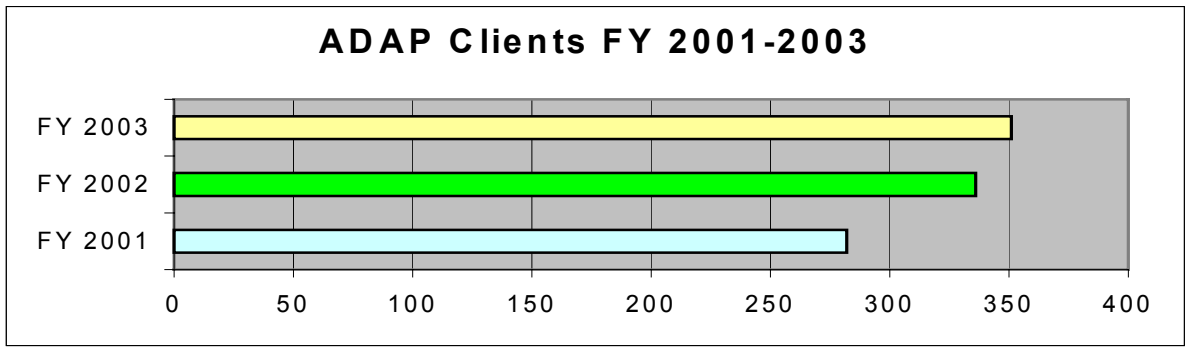


In FY 2003 (April 1, 2003-March 31, 2004), the Ryan White Title II Program also provided funding for the AIDS Drug Assistance Program (ADAP). This program component provides formulary medications for the treatment of HIV disease and related opportunistic infections to qualified clients who have no other access to medications. In FY 2003 a formulary of 101 medications was available to 351 unduplicated clients.

According to the CARE Act Data Report covering calendar year 2003, 78% of clients were male and 22% female. The majority of clients (74%) were white, 24% black, and 2% identifying as Asian, Pacific Islander, or American Indian. 20% of clients served identified their ethnicity as Hispanic or Latino[3].

The following charts demonstrate the three-year trend (FY 2001-2003) in ADAP expenditures and clients served:





[3] Ethnicity is considered a subset of race for CARE Act Data Reporting; meaning clients identifying as Hispanic or Latino also identify a racial category.

Between FY 2001 and FY 2003 expenditures for ADAP increased 15% from $1,158,625 in FY 2001 to $1,363,248 in FY 3003. In the same period unduplicated ADAP clients increased almost 20% from 282 clients in FY 2001 to 351 clients served in FY 2003.

HEPATITIS DATA

In March 2004, the Nebraska Hepatitis C Virus (HCV) Prevention Plan was created by constituents from across Nebraska, representing the professional disciplines involved in the prevention of Hepatitis C within Nebraska. The purpose of the plan is to outline a comprehensive and systemic approach that will aid in the prevention of the spread of the Hepatitis C virus in Nebraska and to limit the progression and complications of Hepatitis C related chronic liver diseases within Nebraska.

Background

The Hepatitis C virus (HCV) is the most common chronic blood borne infection in the United States. The Center for Disease Control and Prevention (CDC) estimates one out of every fifty Americans have been infected with the Hepatitis C virus, 75% of whom have no idea they are infected with the virus and capable of transmitting it to others. These figures are a conservative low as the CDC estimates do not take into account the homeless population or those incarcerated; both of these population groups have a higher percent infection rate than the general public. Any person infected with the Hepatitis C virus can transmit the virus to others at any time during the disease process, and there is no vaccine for the prevention of the Hepatitis C virus. The Center for Disease Control and Prevention (CDC) has predicated a fourfold increase in chronic Hepatitis C infections by the year 2015.

Hepatitis C and HIV Co-Infection

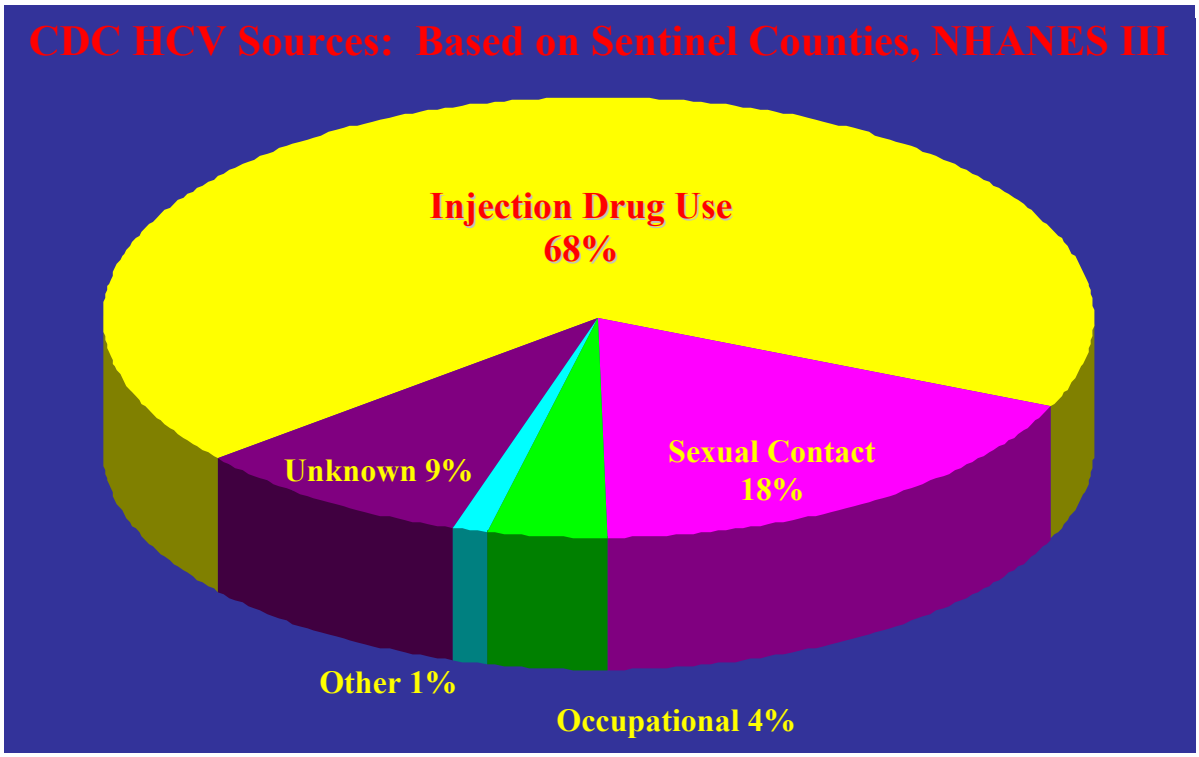
The CDC has estimated that one out of every three people infected with the Human Immunodeficiency Virus (HIV) is also infected with the Hepatitis C virus. The presence of the Hepatitis C virus and HIV in a client can impact both the treatment and management of both HCV and AIDS. Co-infection with the AIDS virus and the Hepatitis C virus has been associated with higher titers of the Hepatitis C virus, a more rapid progression to liver disease and an increased risk for cirrhosis of the liver. Since highly reactive antiretroviral therapy and prophylaxis treatment for opportunistic infections have increased the life span of AIDS patients, Hepatitis C related liver disease has become a major cause of hospital admissions and death among AIDS patients.

Nebraska Hepatitis C Trends

Based on the CDC estimates and 2001 Nebraska census data, statistically there are an estimated 31,307 Nebraskans currently infected with the Hepatitis C virus. As of December 31, 2003, Nebraska carries only 10,375 on the state epidemiology Hepatitis C roster. It is estimated that 20,932 Nebraskans are currently unaware that they are infected with the Hepatitis C virus; 17,792 of which will be chronic and capable of transmitting the disease to others.

Nebraska HCV Statistical Table			
		National Average % HCV positive	NE # Potential Positives
NE 2003 Census	1,739,291	1.8 %	31,307
HCV Known High Risk Populations			
2002 Substance Abuse Treatment Admissions	1,638	50.0 %	819
2000 Nebraska Veteran Population	173,189	7.5 %	12,989
2004 Nebraska Inmate Population	4,034	20.0 %	807
2003 Nebraska Living with HIV/AIDS	1,822	33.0 %	601
		Statistical Positives for Nebraska High Risk Populations	15,216
		NE HCV State Registry Total as of December 31, 2003	10,375
		Estimated un-diagnosed Nebraska HCV cases	20,932

National HCV Trends



Hepatitis C Prevention

As there is no vaccine to prevent the Hepatitis C viral infection, prevention of the spread of this virus is crucial. Because the Hepatitis C virus, the Hepatitis B virus, and the AIDS virus all have similar risk factors and modes of transmission, the CDC has recommended that prevention strategies and efforts for these three viruses be combined. Trial projects by the CDC have shown that by decreasing the spread of the Hepatitis C virus, the spread of HIV and Hepatitis B virus are also reduced.

A. *Primary prevention* methods are aimed at decreasing the rate of new cases of HCV and therefore reducing the transmission rate of the virus to others. Primary prevention methods consist of any of the following:
   - Strategies that decrease sharing of syringes, needles, or works among substance abusers.
   - Strategies that promote liver wellness.
   - Strategies that decrease needle sticks & blood exposures among health care workers.
   - Education of medical professionals and substance abuse counselors on HCV updates and trends.

B. *Secondary prevention* methods are focused at high-risk populations for HCV, aimed at identifying current persons infected with HCV and preventing further spread of the virus. Secondary prevention methods include any of the following:
   - HCV education for substance abuse counselors.
   - HCV education for sexually transmitted disease (STD) counselors.
   - HCV education for Human Immunodeficiency Virus (HIV) counselors.
   - Testing of all donated blood products for the presence of HCV.
   - Virus inactivation of plasma/blood products at blood centers.

<u>Screening Factors for Hepatitis C</u>

A person with any of the following risk factors should be tested for HCV:

1. Any history of IV drug use, even just one time.
2. Any history of intranasal use of cocaine, even just one time.
3. Any client that tests positive for the AIDS virus.
4. Clients with a history of STDs.
5. Occupational exposure to blood.
6. Clients receiving blood products or tissue donations prior to 1992.
7. Hemophiliacs receiving clotting factors prior to 1987.
8. Clients with high-risk sexual behaviors.
9. Clients showing clinical manifestations indicating impaired liver function.
10. Children born to Hepatitis C positive mothers.
11. Clients with an exposure to a known Hepatitis C source.

Hepatitis C Surveillance

In accordance with “Title 173”, the Hepatitis C virus, in both an acute or chronic form, is considered a communicable disease that providers and laboratories are required to report to the Nebraska Health and Human Services epidemiology department. The Viral Hepatitis surveillance officer for Nebraska Health and Human Service Systems is responsible for monitoring the spread of HCV in Nebraska and will work closely with the Hepatitis Prevention Coordinator to identify target populations or areas in Nebraska that demonstrate a need for investigation or intervention.

Surveillance for newly acquired symptomatic HCV is needed as an ongoing monitor of HCV activity and can indicate outbreaks of the disease. Investigation of these cases to determine their characteristics and risk factors provide the best information for monitoring trends in transmission patterns. Since HCV is a progressive disease, often taking years to identify in a patient, limitations exist for the use of positive HCV antibody laboratory reports to conduct surveillance for HCV infections. However, these reports can be an important source from which state and local health departments can identify HCV infected persons who need counseling and medical follow-up. Surveillance of chronic HCV cases will play a crucial role in identifying priority populations or areas of Nebraska needing interventions.

Hepatitis Prevention Future Plans

1. Create a network of HCV support groups across Nebraska, with a trained support group leader to facilitate each group.
2. Expand the state HCV prevention plan to incorporate HBV and the co-infections of HBV and HCV with HIV.
3. "Liver Wellness" program initiated into Nebraska's 3rd grade classes.
4. Increase the medical community's awareness regarding the current "Silent Epidemic" of HCV. This will be done through continuing education opportunities at conferences and workshops across Nebraska, targeting nurses, substance abuse counselors, public health officials, and the Nebraska Department of Corrections.
5. Increase public awareness regarding risk factors for HCV through health fairs, public service announcements, newspaper articles, and coordinated activities during the month of May, which is Hepatitis Awareness Month, and the month of October, which is national Liver Awareness Month.
6. In 2003, Nebraska hired a full time Hepatitis surveillance officer who is currently cleaning up previous databases and incorporating everything into the new National Electronic Data System required by the CDC.
7. Provide each of the 23 public health departments within Nebraska with a copy of all CDC guidelines and recommendations related to viral hepatitis.
8. Provide each of the 11 Nebraska Department of Corrections facilities copies of the Viral Hepatitis curriculum developed by the National Commission on Correctional Health Care. Each set of the curriculum contains presentations on viral hepatitis for both the inmates and the staff of a correctional setting.

SEXUALLY TRANSMITTED DISEASE (STD) DATA

Overview

Chlamydia infections are the most frequently reported disease in the United States (about 852,000 in 2002), and in Nebraska (4,810 chlamydia infections accounted for 60% of all reported STDs cases in 2002). In woman, chlamydial infections are usually unknown and may result in pelvic inflammatory disease (PID). PID is a major cause of infertility, ectopic pregnancy, and chronic pelvic pain. As with other inflammatory STDs, chlamydia can facilitate the transmission of HIV infection two to five fold. Furthermore, pregnant women infected with chlamydia can pass it on to their infants during delivery and potentially cause infection of the baby's eyes and chlamydial pneumonia.

Reported incidence of early syphilis in the United States is at the lowest level since reporting began in 1941. Nonetheless, outbreaks of syphilis among men who have sex with men have been reported recently, possibly reflecting an increase in risk behavior associated with enhanced drug therapy for HIV infection. In Nebraska, one early syphilis case was reported during the first half of Year 2003. Nebraska is maintaining a low case rate with a projected syphilis rate for the Year 2003 of 0.2/100,000. Syphilis is a genital ulcerative disease that is transmitted through direct contact with a syphilis lesion. It has shown to facilitate the transmission of HIV 10 to 50 times for male to female through vaginal sex and 50 to 300 times for female to male through vaginal sex. In infant health, syphilis is a factor because congenitally acquired syphilis can have devastating results. No congenital syphilis was reported for the first half of 2003.

In calendar year 2000 in the United States, 358,995 cases of gonorrhea were reported, resulting in a rate of 131 per 100,000 (Nebraska reported 1,572 cases and 92 rate per 100,000 in 2002). As with chlamydia, gonorrhea can facilitate the transmission of HIV infection two to five fold. During the first half of Year 2003, 688 cases of gonorrhea were reported in Nebraska (Douglas, Sarpy and Lancaster Counties account for 92% of reported gonorrhea cases). The projected case rate/100,000 for Year 2003 is 80/100,000.

In Nebraska there were 6,242 reported new cases of STDs in 1999, resulting in an incidence rate of 364.8 new cases per 100,000 population. The Nebraska figure includes new cases of chlamydia, gonorrhea, early syphilis, and genital herpes. The overall rate per 100,000 population increased 16% from 364.8 in 1999 to 422.2 in 2003. The highest percent change in rate per 100,000 population was seen in primary syphilis (from 4 cases in 2002 to 11 cases in 2003), which equates to a 200% increase. Genital herpes numbers are for first episodes only.

Increases in these diseases is due primarily to population growth and an increased use of screening and more sensitive testing methods of more new infections. Still, many people who are at risk for these infections are not being tested due to a lack of awareness among health care providers and limited resources available for proper health care.

Reported Chlamydia, Gonorrhea, and Syphilis Cases Rates 1999-2003

Chlamydia 1999-2003

- Reported rates of new chlamydia infections are much higher among females than males in the United States, reflecting the larger number of women screened for the disease. In 1999, the rate for females in Nebraska was (398), nearly four times the rate for males (146).
- Sexually active adolescents in the United States have a high rate of chlamydial infection. In Nebraska, rates for teens, 15-19 year olds, was the second highest (1204.6) in 2003. Young aged adults (20-24 year olds) were the highest by far with a rate of 1391.1 in 2003.
- As is the case with STDs in general, chlamydia incidence rates for non-Hispanic African Americans in Nebraska are much higher than rates for other racial or ethnic groups. Over a one year period, the rate (1813.3) for non-Hispanic African Americans was about thirteen times the rate (142.2) for non-Hispanic whites. The rate (420.9) for Hispanic Americans was more than three times the rate for non-Hispanic whites.

Gonorrhea 1999-2003

- Reported rates of new gonorrhea infections are much higher among females than males in the United States, reflecting the larger number of women screened for the disease. In 2003, the rate for females in Nebraska was (108.6), 31% higher than the rates for males (82.6).
- Rates of infection are disproportionately higher in adolescents than in young adults, especially among racial and ethnic minorities. The highest age specific report of gonococcal infection occurred among 20-24 year olds in 2003 at a rate of 409.5. The rate for 15-19 year olds was nearly as high, with a rate of 363.
- Nationwide, the incidence rate for gonorrhea among non-Hispanic African Americans was thirty times the rate for non-Hispanic whites. The incidence rates for Hispanics and Native Americans were also much higher than rates for non-Hispanic whites. In Nebraska, the incidence of gonorrhea was far higher for non-Hispanic African Americans (1047.5) in 2003. This equates to a rate (23.6) that is forty-five times higher than non-Hispanic whites. Rates for Native Americans (110.6) and Hispanic Americans (48.3) in the state were also higher than the non-Hispanic white rate.

Syphilis 1999-2003

- In 2000, there were 5,979 reported cases of primary syphilis nationwide or 2.2 cases per 100,000 population. In Nebraska, rates have decreased since the early 1990‘s, with only eleven cases reported in 2003 with a rate of 0.6. In 1999, the incidence rate for primary and secondary syphilis reported for non-Hispanic African Americans was 1.4 cases per 100,000, which is approximately twice the rate for non-Hispanic whites (0.6). No cases were reported for Asian Americans or Hispanics in 2003.

Number of Cases and Incidence Rates (per 100,000 pop) of STDs 1999-2003

STD	1999		2000		2001		2002		2003		% Rate Change
	No.	Rate	No.	Rate	No.	Rate	No.	Rate	No.	Rate	2002/2003
Chlamydia	3,616	211.3	3,799	222.0	3,196	186.8	4,595	268.2	4,825	279.0	4.0
Gonorrhea	1,472	86.0	1,537	89.8	1,187	69.4	1,423	83.1	1,664	96.2	15.8
Pri/Sec Syphilis	6	0.4	2	0.1	6	0.4	4	0.2	10	0.6	200.0
Early Latent Syphilis	5	0.3	1	0.1	0	0.0	0	0.0	1	0.1	
Genital Herpes	967	56.5	963	56.3	673	39.3	779	45.5	648	37.5	-17.6
All STDs	6,242	364.8	6,494	379.5	5,177	302.5	6,934	404.7	7,301	422.2	4.3

Reported Chlamydia, Gonorrhea, and Syphilis Cases and Incidence Rates 2003

In the demographic groups, the Eastern Service Area had the highest reported chlamydia (3,866), gonorrhea (1,601), and syphilis (8) cases. When reviewing the most populous counties, Douglas County had the highest reported cases of chlamydia, gonorrhea, and syphilis. Overall, the most populated areas of Nebraska, such as Lancaster and Douglas counties, reflect the greatest number of cases, as well as the largest amount of morbidity.

Number of Cases and Incidence Rates (per 100,000 pop) of Chlamydia, Gonorrhea, and Primary & Secondary Syphilis by Residence, Age, Gender, and Race/Ethnicity, 2003

DEMOGRAPHIC GROUP	Chlamydia		Gonorrhea		Pri/Sec Syphilis	
Residence	No.	Rate	No.	Rate	No.	Rate
Western Service Area	288	147.0	11	5.6	0	0
Central Service Area	671	137.9	52	10.7	2	0.4
Eastern Service Area	3,866	369.3	1,601	153.0	8	0.8
Douglas County	2,620	554.2	1,218	257.0	7	1.5
Lancaster County	843	327.4	307	119.2	0	0
Sarpy County	280	216.5	48	37.1	1	0.8
Age						
<10	14	6.0	2	0.9	0	0
10-14	99	78.5	33	26.2	0	0
15-19	1,596	1,204.6	481	363.0	0	0
20-24	1,815	1,391.1	534	409.5	0	0
25-29	644	574.2	255	227.4	1	0.9
30-34	232	204.8	123	108.6	3	2.6
35-44	168	66.0	135	53.0	3	1.2
45+	36	5.8	48	7.7	3	0.5
Gender						
Males	1,249	146.3	705	82.6	9	1.1
Females	3,489	398.4	951	108.6	1	0.1
Race						
White	2,268	142.2	377	23.6	9	0.6
Black	1,307	1,813.3	755	1,047.5	1	1.4
American Indian	129	792.4	18	110.6	0	0
Asian	45	163.0	5	18.1	0	0
Other	46	92.0	8	16.0	0	0
Ethnicity						
Hispanic	436	420.9	50	48.3	0	0

YOUTH RISK BEHAVIOR SURVEILLANCE (YRBS) DATA

Overview

In the United States, 70.8% of all deaths among youth and young adults aged 10-24 years result from only four causes: motor-vehicle crashes, other unintentional injuries, homicide, and suicide. Substantial morbidity and social problems also results from the approximately 870,000 pregnancies that occur each year among females aged 15-19 years and the estimated three million cases of sexually transmitted diseases (STDs) that occur each year among persons aged 10-19 years.

Among adults aged 25 years and older, 62.9% of all deaths in the United States result from cardiovascular disease and cancer. Leading causes of morbidity and mortality among all age groups in the Untied States are related to the following: behaviors that contribute to unintentional injuries and violence; tobacco use; alcohol and other drug use; sexual behaviors that contribute to unintended pregnancy and STDs, including HIV infection; unhealthy dietary behaviors; physical inactivity; and becoming overweight. Behaviors are frequently interrelated and often are established during youth and extend into adulthood.

To monitor priority health-risk behaviors among youth and young adults in each of these six categories, CDC developed the Youth Risk Behavioral Surveillance System (YRBSS). YRBSS includes national, state, and local school-based surveys of students in grades 9-12. Since 1991, national surveys are conducted biennially. Comparable state and local surveys are conducted in a similar timeframe.

Summary of Results Related to Sexual Behaviors that Contribute to Unintended Pregnancy and STDs, Including HIV Infection

Nationwide, 46.7% of students had had sexual intercourse during their lifetime, compared to 42.8% of Nebraska students. Nationwide, 7.4% of students had sexual intercourse for the first time before age 13 years, compared to 5.1% of Nebraska students. In the United States, 14.4% of students had had sexual intercourse during their lifetime with four or more partners, compared to 12% of Nebraska students. Approximately one third (34.3%) of students nationwide had had sexual intercourse during the three months preceding the survey (i.e., currently sexually active), compared to 31.5% of Nebraska students. Among the 34.3% of currently sexually active students nationwide, 63% reported that either they or their partner had used a condom during their last sexual intercourse and 17% reported either they or their partner had used birth control pills to prevent pregnancy before their last sexual intercourse. Among the 31.5% of currently sexually active students in Nebraska, 60.2% reported they or their partner had used a condom during their last sexual intercourse and 21.9% reported they or their partner had used birth control pills to prevent pregnancy before their last sexual intercourse. In addition, among the 34.3% of currently sexually active students nationwide, 25.4% had drunk alcohol or used drugs before their last sexual intercourse. In contrast, among the 31.5% of currently sexually active students in Nebraska, 30.5% had drunk alcohol or used drugs before their last sexual intercourse - a 5.1% increase over the national average. Nationwide, 4.2% of students had been pregnant or had gotten someone pregnant, compared to 3.4% of students in Nebraska. Finally, nationwide 87.9% of students had been taught in school about AIDS or HIV infection, compared to 85% of Nebraska students.

CDC 2003 Youth Risk Behavior: 9th-12th Grade

STATISTIC	UNITED STATES	NEBRASKA
Ever Had Sexual Intercourse	46.7%	42.8%
First Sexual Intercourse < 13 Years	7.4%	5.1%
>4 Sex Partners in Lifetime	14.4%	12.0%
Currently Sexually Active	34.3%	31.5%
Condom Use During Last Sexual Intercourse	63.0%	60.2%
Birth Control Use Before Last Sexual Intercourse	17.0%	21.9%
Alcohol or Drug Use Before Last Sexual Intercourse	25.4%	30.5%
Had Been Pregnant or Gotten Someone Pregnant	4.2%	3.4%
Taught in School About AIDS or HIV Infection	87.9%	85.0%

BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM (BRFSS) DATA

Overview

- The Nebraska Behavioral Risk Factor Surveillance System (BFRSS) has been conducting surveys annually from 1986 through today for the purpose of collecting data on the prevalence of major health risk factors among adults residing in the state. Information gathered in these studies can be used to target health education and risk reduction activities in order to lower rates of premature death and disability.

- This surveillance system is based on a research design developed by the Centers for Disease Control and Prevention (CDC) and used in all fifty states, the District of Columbia, and three U.S. territories.

- Telephone surveys with 5,921 randomly selected Nebraska residents aged 18 and older were conducted by the Nebraska Health and Human Services during 1999-2000.

Summary of Results

- The majority of adults aged 18 through 64 (88%) stated that, if they had a sexually active teenager, they would encourage him or her to use a condom. The proportion of respondents who would encourage this practice for sexually active adolescents was highest among young adults.

- When asked to assess their chances of getting infected with HIV, 6% of Nebraska adults under age 65 rated their risk as "high" or "medium." Respondents' perceptions of their risk of infection have decreased somewhat from previous studies, when 8% or 9% considered themselves at high or medium risk of HIV infection.

- Approximately one-third of BRFSS respondents aged 18 to 64 years (34%) said their blood had been tested for HIV infection (excluding tests they may have had as part of blood donations).

- Nearly three-fourths (72%) of BRFSS respondents aged 18 to 64 years thought that children should begin learning about HIV/AIDS by the end of sixth grade. A substantial proportion (27%) felt that education on this topic should begin even earlier - by the end of third grade. One in ten respondents (10%) did not know or refused to state when children should start learning about this disease.

- Men (7%) were a little more likely than women (5%) to report being at high or medium risk for getting this disease. Similar proportions of urban (5%) and rural (6%) residents considered themselves at high or medium risk for contracting HIV.

- The proportion of persons at high or medium risk for HIV was similar across educational levels. Persons with annual household incomes under $20,000 (7%) were slightly more likely than those with incomes of $50,000 or more per year (5%) to report being at high or medium risk of contracting HIV infection.

- Men (35%) and women (33%) were about equally likely to have had their blood tested for this infection. One-half of young adults aged 25 to 34 (50%) had ever been tested for HIV. Among 35 to 44 year olds, 38% reported being screened for infection with the virus, as did 32% of 18 to 24 year olds. The proportion that had been tested was lower among respondents aged 45 and older.

- Reasons for having their blood tested for HIV infection varied, but two-thirds of the respondents (68%) stated that the HIV blood test was done as a routine requirement of some kind. They frequently said that it was performed as part of a pregnancy exam, a routine checkup, or as part of the application for life insurance. Others mentioned that this test had been done for induction into the military, as preparation for hospitalization or a surgical procedure, or when applying for health insurance.

- One-fourth of the respondents who had been tested (25%) cited reasons that may indicate that the respondent felt he or she was at increased risk for contracting HIV. Sixteen percent (16%) had their blood tested "for my own information," while 4% had the test because they had been exposed to the virus through their occupation.

- When asked where they had their last test for HIV, 40% of respondents said a private physician or HMO did the testing. Fifteen percent (15%) reported being tested for HIV at the hospital. Other sites frequently mentioned include: military site (10%), home visits by a nurse or health worker (6%), and insurance company clinics (5%).

- Among those ever tested for HIV infection, eight out of ten (81%) indicated that they had received their test results. Of those who had, however, approximately one-third (32%) said they had received any counseling or talked with a health professional about the results of the test.

HEALTH STATUS OF RACIAL AND ETHNIC MINORITIES IN NEBRASKA

Introduction

In September 2003, the Nebraska Office of Minority Health provided health workers with a comprehensive report, "Health Status of Racial and Ethnic Minorities in Nebraska." Most Nebraskans enjoy a relatively healthy and good quality of life. There continues, however, to be significant disparity in the overall health status and quality of life for racial/ethnic minorities in the state. Since the establishment of the Office of Minority Health in 1992, it has become increasingly apparent that health care professionals, community advocates, and consumers must develop effective ways of meeting the challenges presented by our rapidly changing and culturally diverse society. The information and data outlined below is taken from the section of the plan on HIV/AIDS.

Overview

In 1981, AIDS was identified as a new infectious disease in the United States. By the end of 2001, the cumulative number of AIDS cases reported to the CDC is more than 816,149 nationwide. Of these, adult and adolescent AIDS cases totaled 807,074, with males contributing 82.5% or 666,026. Females contributed 141,048 or 17.5%. Furthermore, the CDC has documented that as of December 31, 2001, 467,910 deaths among people with AIDS, 462,653 adults and adolescents and 5,257 children under age 13, as well as 360 persons whose age at death were not known. AIDS is now the fifth leading cause of death for African American men in this age group, according to CDC's HIV/AIDS Statistics, NIAID Fact Sheet of December 2002.

According to CDC, more people in the U.S. than ever before are living with HIV. As of December 2002, CDC's latest estimates indicate that 850,000 to 950,000 people in the United States are currently infected with HIV. However, CDC estimates that one-quarter or 212,5000 to 237,500 of these persons may not be aware of their infection, while 362,827 people in the U.S. were living with AIDS as of the end of 2001. According to the CDC, of the estimated 15,603 AIDS-related deaths in the U.S. in 2001, approximately 52% were among African Americans, 29% among whites, 18% among Hispanics, and less than 1% among Asians/Pacific Islanders and American Indians/Alaska Natives.

Disparities in the rate of infection among certain racial and ethnic groups, particularly high rates for African Americans and Hispanic Americans, remain a challenge. New treatments have reduced illness, disability and death due to HIV/AIDS, but lack of access to culturally and ling

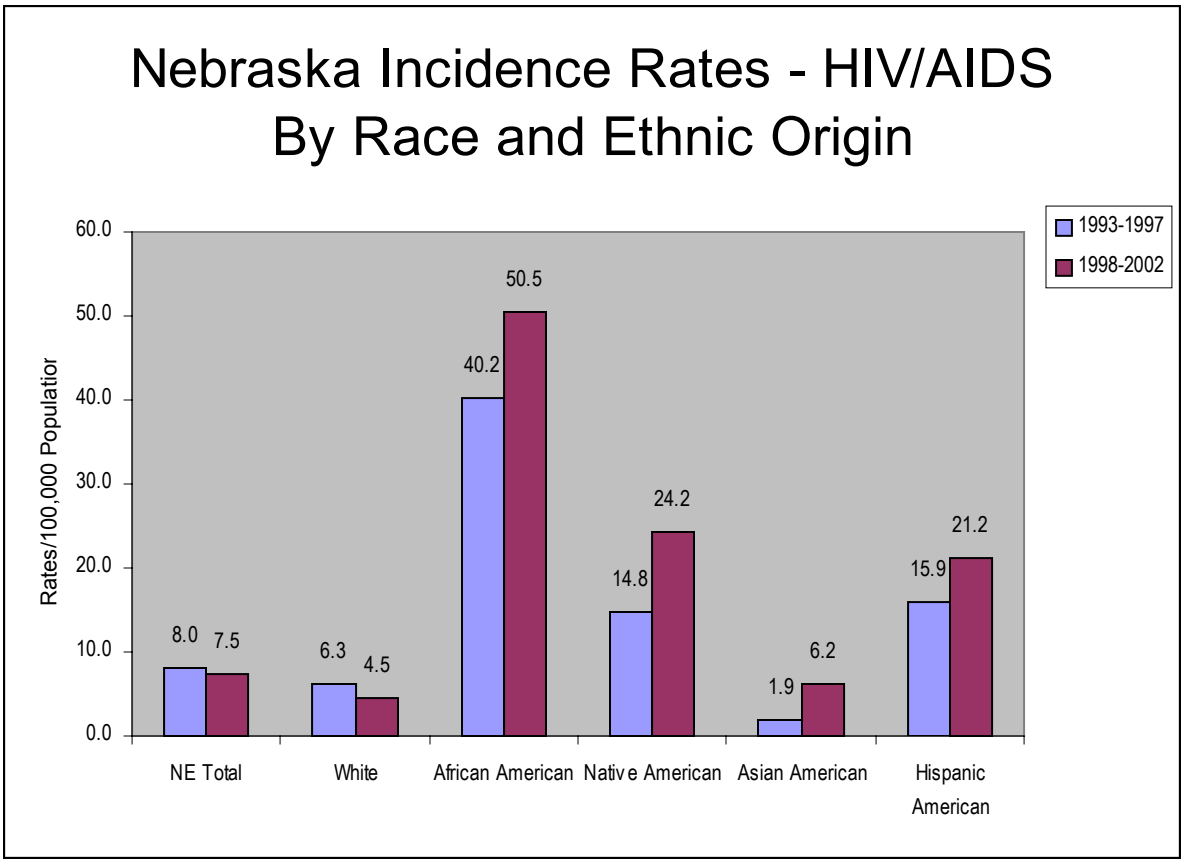
In Nebraska, through June 30, 2003, the total number of AIDS cases reported since record keeping began in January 1983 was 1,265. Of these, males accounted for 85.6% (1,083) and females 14.4% (182). A little over two-thirds (867) of all AIDS cases in the state (68.5%) occurred among African Americans and 9.6% or 121 among Hispanic Americans. Asian Americans accounted for only eight (8) of the total cases, while Native Americans accounted for eighteen (18) or 1.4% of all AIDS cases. In retrospect, as of June 30, 2002, the total number of AIDS cases reported since January 1983 was 1,197.

In 2002, there were a total of 50 HIV and 72 AIDS cases reported in Nebraska. AIDS cases were at a rate of 4.2 per 100,000 population. To date, a total of 679 persons are known to have died from AIDS, while 557 are still living, according to the HHS HIV/AIDS Surveillance Report, December 2002.

Incidence

As is true nationwide, minorities in Nebraska are over-represented among persons who have HIV or AIDS. Although minorities make up only about 12.7% of the population of the state, 31% of the cumulative AIDS cases through 2002 occurred among minority Nebraskans. In 2002 alone, of the 4,372 new AIDS cases reported, African Americans accounted for 40%, Hispanics 10%, and Asian Americans less than 4%, while whites account for 47%.

In Nebraska, one year trends by race or ethnicity are difficult to establish because of the small number of cases reported each year. Thus, average yearly rates for two five year periods will be compared instead. For white Nebraskans, the average rate of new HIV and AIDS cases decreased from 6.3 to 4.5 cases per 100,000. Incidence rates of new HIV and AIDS cases rose for all four racial and ethnic minority groups in the state for 1998-2002 versus 1993-1997.



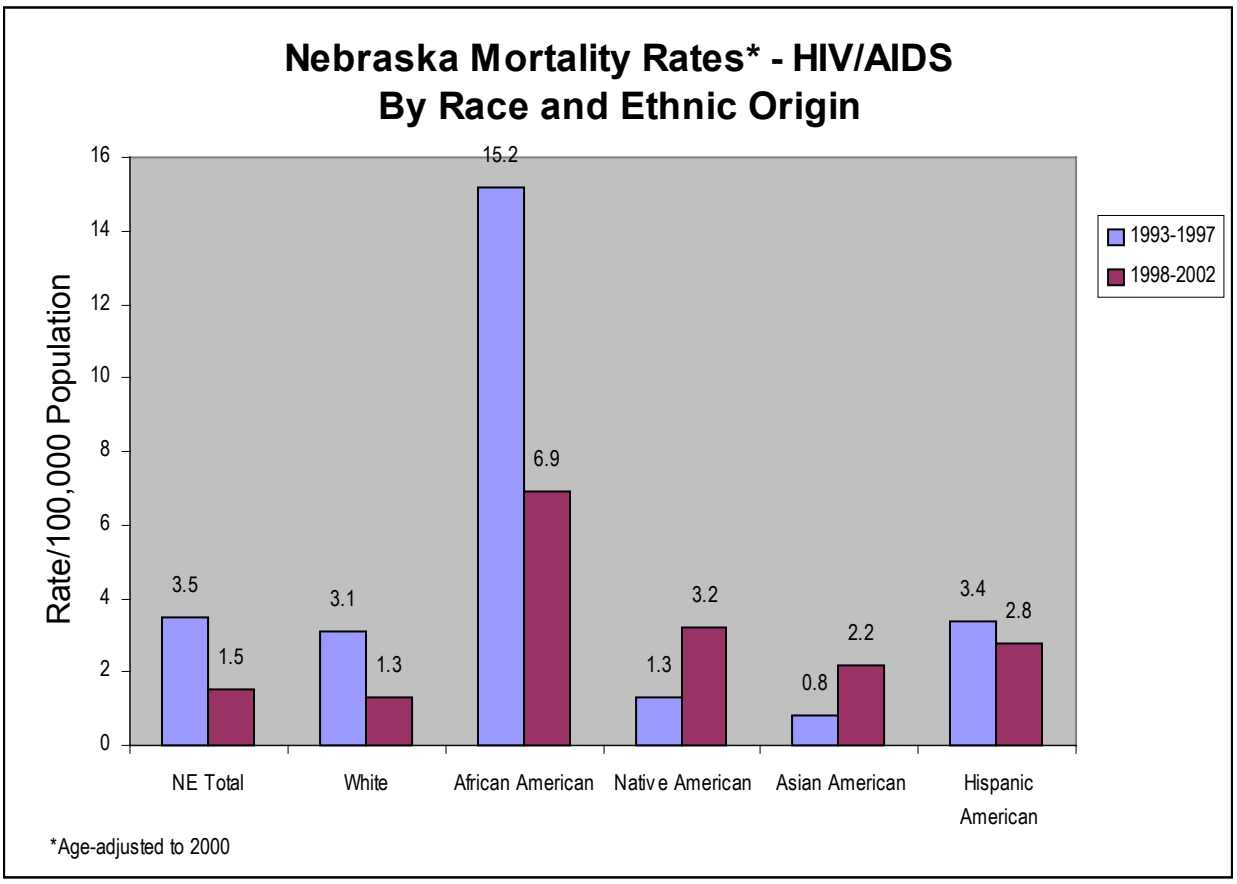
Among African Americans, the average rate of new HIV and AIDS cases in 1998-2002 was 50.5, up 10.3% from the previous five year period. The HIV/AIDS rate for African Americans is 11.2 times higher than the rate for whites in Nebraska.

HIV/AIDS
Incidence Rates and Relative Risk of Disease
for Nebraska Racial and Ethnic Minority Populations

CATEGORY	1993-1997		1998-2002	
HIV/AIDS	Incidence Rate Per 100,000 Population	Relative Risk	Incidence Rate Per 100,000 Population	Relative Risk
Nebraska Total	**8.0**		**7.5**	
White	6.3		4.5	
African American	40.2	6.4	50.5	11.2
Native American	14.8	2.4	24.2	5.4
Asian American	1.9	0.3	6.2	1.4
Hispanic American	15.9	2.5	21.2	4.7

Mortality Rates

The number of deaths due to AIDS has declined nationally with 15,603 deaths occurring in 2001 and 16,672 in 2000. In Nebraska, deaths due to this disease decreased from 61 in 1996 to 33 in 2001, according the Nebraska Vital Statistics Report. Currently, AIDS has moved out of the top fifteen causes of death for the overall population in the nation and the state.



For whites, the age-adjusted mortality rate for AIDS declined from the previous five years to 1.3 deaths per 100,000 population for 1998-2002. For African Americans, the 1998-2002 rate (6.9) is 5.3 times the white rate, though, a decrease of more than 54% from the rate of 15.2 for 1993-1997. For African American males in Nebraska, the current death rate due to HIV/AIDS is 5.5 times the rate for white males. The mortality rate for Hispanic Nebraskans (2.8) indicates a slight decline of 17.6% from the rate of 3.4 for 1993-1997, according to the Nebraska Vital Statistics Report, 1998-2002. Hispanic males are 1.9 times more likely to die of HIV/AIDS than whites.

HIV/AIDS Mortality Rates and Relative Risk of Mortality for Nebraska Racial and Ethnic Minority Populations

	1993-1997		Relative Risk			1998-2002		Relative Risk		
Category	Number of Deaths	Age-Adjusted* Mortality Rate per 100,000 Population	Total	Males	Females	Number Of Deaths	Age-Adjusted* Mortality Rate per 100,000 Population	Total	Males	Females
HIV/AIDS Nebraska Total	**277**	**3.3**				**123**	**1.5**			
White	230	3.1	1.0	1.0	1.0	98	1.3	1.0	1.0	1.0
African American	45	15.2	4.9	4.5	11.2	21	6.9	5.3	5.5	**
Native American	1	1.3	0.4	**	**	2	3.2	2.5	**	**
Asian American	1	0.8	0.3	**	**	2	2.2	1.7	**	**
Hispanic American	9	3.4	1.1	1.1	**	10	2.8	2.2	1.9	**

* Age-adjusted to 2000
** Number of deaths less than 5

Years of Potential Life Lost (YPLL) Due to AIDS

Altogether, deaths from AIDS in Nebraska from 1998 to 2002 accounted for an estimated 298.3 years of potential life lost annually among racial and ethnic minority residents of the state. This number was 0.6 times the YPLL average for AIDS for 1993-1997 (540 years).

YPLL rates have increased for each racial and ethnic group in Nebraska, except for African Americans, although they still lost 4.7 times as many years of potential life per person due to HIV/AIDS as whites in the state in 1998-2002. Native Americans lost 2.5 times as many years of potential life per person as whites in Nebraska, while Hispanics lost 1.9 as many years of potential life per person.

Years of Potential Life Lost - HIV/AIDS
Based on 75 Productive Years of Life
for Nebraska Racial and Ethnic Minority Population

	1993-1997			1998-2002		
Category	# of Total YPLL	Age-Adjusted Rate/100,000	Minority -to- White Ratio*	# of Total YPLL	Age-Adjusted Rate/100,000	Minority -to- White Ratio*
HIVAIDS Nebraska Total	**10,415**	**129.8**		**4,221.0**	**51.4**	
White	8,606	114.2		3,384.0	45.9	
African American	1,718	551.3	4.8	706.0	216.7	4.7
Native American	46	57.7	0.5	71.0	113.4	2.5
Asian American	46	35.1	0.3	61.0	66.4	1.4
Hispanic American	350	129.3	1.1	355.0	86.6	1.9
Average/Year (Minorities)	**540**			**298.3**		

*Minority Age-Adjusted YPLL Rate/100,000 divided by White Age-Adjusted YPLL Rate/100,000

Risk Factors For HIV/AIDS Infection

Transmission of HIV occurs primarily in three ways: sexual contact, intravenous drug use, and perinatal contact with an infected mother. The screening of donated blood since 1985 for HIV antibodies has nearly eliminated blood transfusions as a risk for acquiring AIDS.

In 1996-2000, 79.4% of 403 total AIDS cases occurred among men. Men who have sex with men (MSM) represented 59% of all 320 men reported with AIDS. In addition, increasing numbers of women, children, adolescents and injecting drug users are being infected. The fastest growing means of HIV transmission, especially among women, is heterosexual contact. Of the 403 total cases, 20.6% or 83 occurred among Nebraska women, according to the Nebraska HIV/AIDS Surveillance Report, 2002.

In Nebraska, based on cumulative reported cases of AIDS through 2002, the majority of cases occurred among MSM (54%). Ten percent (10%) of cases were reported for each of the following categories: injecting drug use, heterosexual contacts, and risk not identified (RNI), while 9% of the cases occurred among men who have sex with men and use injectable drugs (MSM/IDU) as well.

Progress Toward Objectives

It is important to note that while the national data provides a fairly accurate view of HIV/AIDS trends, they do not include data from persons tested anonymously. Approximately two-thirds of people living with HIV infection are already tested and are aware of their status. Based on a decreasing trend, the Nebraska 2010 objective for number of new diagnosed cases of AIDS for African Americans was set at no more than the rate of 1.0 new cases/100,000 population for the year. This objective was not achieved based on the average annual incidence for 1998-2002 of 173 cases, at the rate of 50.5 cases per 100,000.

HIV/AIDS
Baseline, Current Data, and Year 2010 Objectives
for U.S. and Nebraska Racial and Ethnic Minority Populations

Indicator And Target Groups	Nebraska Baseline (1993-1997)	Nebraska Current Rate (1998-2002)	Nebraska % Change Current vs. Baseline Rates	Nebraska Year 2010 Objective	U.S. Current Rate (2000)	U.S. Year 2010 Objective
Annual Incidence of Diagnosed HIV/AIDS Cases**						
African Americans (# of cases) Rate/100,000 Pop. aged 13+	133 (Cases)* **40.2**	173 (Cases) **50.5**	25.6 %	1.0	58.1	1.0
Hispanic Americans (# of cases) Rate/100,000 Pop. aged 13+	54 (Cases)* **15.9**	100 (Cases) **21.2**	33.3 %	1.0	22.5	1.0
Native Americans (# of cases) Rate/100,000 Pop. aged 13+	11 (Cases)* **14.8**	18 (Cases) **24.2**	63.5 %	1.0	9.8	1.0
Asian American (# of cases) Rate/100,000 Pop. aged 13+	2 (Cases)* **1.9**	7 (Cases) **6.2**	226.3 %	1.0	3.4	1.0

*HIV Numbers are incomplete, since HIV reporting did not begin until September 1995
**Includes both HIV and AIDS Cases: Rates, Age-Adjusted to 2000

For Hispanic Americans, the target number was set at no more than the rate 1.00 per 100,000 population of diagnosed new cases of AIDS in the year 2010. Based on 1998-2002 incidence, the incidence rate was 24.2. The year 2010 objective for AIDS incidence for this population group was not met.

ELIMINATING RACIAL AND ETHNIC DISPARITIES IN THE STD PROGRAM

The U.S. Healthy People 2010 report uses the amount of clients attending Family Planning who are diagnosed with chlamydia as a rough estimate of prevalence of chlamydia in the 15 to 24 aged population for all races. Nationwide (calendar year 2002), 5% of females were infected with chlamydia attending Family Planning Clinics.

During October 1, 2002 - September 30, 2003, the prevalence of positive chlamydia screening results in black females (13.7%) attending Nebraska Family Planning is 8.7% higher when compared to the Family Planning national rate of 5%.

- The chlamydia rate in black females is 1% higher than the Nebraska 2000 chlamydia baseline rate of 12.7% and 10.7% higher than the 2010 objective rate of 3%.
- Native American females had the third highest chlamydia prevalence rate of 5.6%. This is lower when compared to the Nebraska 2000 chlamydia baseline rate of 11.4% and higher when compared to the 2010 objective rate of 3%.
- n Hispanic females attending Family Planning, the prevalence of positive chlamydia screening results of 6.7% is higher when compared to the Nebraska 2000 chlamydia baseline rate of 5.4% and higher when compared to the 2010 objective rate of 3%.

Chlamydia testing has increased in the minority population by 67% (from 2,651 tests in 2001 to 4,434 in 2002). Overall, 4.8% females 15 to 24 years attending Family Planning sites tested positive for chlamydia. A reduction of 1.8% is needed to reach the 3% goal of the STD Program.

Females by Race
Attending Family Planning Sites Ages 15-24
Infected with Chlamydia

Family Planning Sites	Black Females Age 15-24	White Females Age 15-24	Asian Females Age 15-24	Native Amer Females Age 15-24	Total Females Age 15-24
# Tested	633	12,127	129	36	**13,170**
# Positive	87	521	4	2	**636**
% Positive	13.7%	4.3%	3.1%	5.6%	**4.8%**

*** Other race (22 positives/245 tested)**

Females by Ethnicity
Attending Family Planning Sites Ages 15-24
Infected with Chlamydia

Family Planning Sites	Hispanic Females Age 15-24	Not Hispanic Females Age 15-24	Total Females Age 15-24
# Tested	1,117	11,765	**13,170**
# Positive	75	540	**636**
% Positive	6.7%	4.6%	**4.8%**

* **Unknown (21 positives/288 tested)**

The U.S. Healthy People 2010 report uses the amount of clients attending Family Planning or STD clinics who are diagnosed with chlamydia as a rough estimate of prevalence of chlamydia in the 15 to 24 aged population for all races. Nationwide (calendar year 2002) in females attending STD Clinics, 12.2% were found to have chlamydia.

- During October 1, 2002 - September 30, 2003, the prevalence of positive chlamydia in black females attending Nebraska STD Clinics was 4.8% higher when compared to the STD Clinic national rate of 12.2%. When compared to the Nebraska 2000 chlamydia baseline rate of 17.5%, it was a half of percent lower. The chlamydia rate in black females is 14% higher when compared to the 2010 objective rate of 3%.
- Native American females attending STD Clinics had the second highest chlamydia prevalence rate of 9.1%. This is 15.9% lower when compared to the Nebraska 2000 chlamydia baseline rate of 25% and 6.1% higher when compared to the 2010 objective rate of 3%.
- In Hispanic females attending STD Clinics, the prevalence of positive chlamydia screening results of 7.9% is 1.7% lower when compared to the Nebraska 2000 chlamydia baseline rate of 9.6% and 4.9% higher when compared to the 2010 objective rate of 3%.

Overall, 9.6% females 15 to 24 years attending STD Clinics sites tested positive for chlamydia. A reduction of 6.3% is needed to go to reach the 3% goal of the STD Program.

Females by Race
Attending STD Clinics Ages 15-24
Infected with Chlamydia

STD Clinics	Black Females Age 15-24	White Females Age 15-24	Asian Females Age 15-24	Native Amer Females Age 15-24	Total Females Age 15-24
# Tested	856	3,646	113	506	**5,390**
# Positive	146	281	10	51	**517**
% Positive	17%	7.7%	8.8%	9.1%	**9.6%**

***Other race (29 positives/218 tested)**

Females by Ethnicity
Attending STD Clinics Ages 15-24
Infected with Chlamydia

STD Clinics	Hispanic Females Age 15-24	Not Hispanic Females Age 15-24	Total Females Age 15-24
# Tested	809	4,206	**5,390**
# Positive	64	416	**517**
% Positive	7.9%	9.8%	**9.6%**

*** Unknown (37 positives/375 tested)**

The U.S. Healthy People 2010 report uses the amount of clients attending Family Planning or STD clinics who are diagnosed with chlamydia as a rough estimate of prevalence of chlamydia in the 15 to 24 aged population for all races. Nationwide (calendar year 2002) in males attending STD clinics, 15.7% had chlamydia.

- The chlamydia rate in black males is (2.4%) higher when compared to the Nebraska 2000 chlamydia baseline rate of 20.1% and 18.5% higher when compared to the 2010 objective rate of 3%.
- Native American males attending STD Clinics had the second highest chlamydia prevalence rate of 13.4%. The chlamydia rate is 12.4% lower when compared to the Nebraska 2000 chlamydia baseline rate of 25% and the chlamydia rate 10.4% higher when compared to the 2010 objective rate of 3%.
- In Hispanic males attending STD Clinics, the prevalence of positive chlamydia screening results of 9.8% and is 2.9% lower when compared to the Nebraska 2000 chlamydia baseline rate of 12.7%.

When compared to the 2010 objective rate of 3%, the chlamydia rate is 6.8% higher. Overall, 14.9% males 15 to 24 years attending STD Clinic sites tested positive for chlamydia. A reduction of 11.9% is needed to go to reach the 3% goal of the STD Program.

Males by Race
Attending STD Clinics Ages 15-24
Infected with Chlamydia

STD Clinics	Black Males Age 15-24	White Males Age 15-24	Asian Males Age 15-24	Indian Males Age 15-24	Total Males Age 15-24
# Tested	1,048	1,509	21	115	**2,854**
# Positive	236	161	1	15	**426**
% Positive	22.5%	10.7%	4.7%	13.4%	**14.9%**

*** Other race (13 positives/161 tested)**

Males by Ethnicity
Attending STD Clinics Ages 15-24
Infected with Chlamydia

STD Clinics	Hispanic Males Age 15-24	Not Hispanic Males Age 15-24	Total Males Age 15-24
# Tested	376	2,359	**2,854**
# Positive	37	364	**426**
% Positive	9.8%	15.4%	**14.9%**

* **Unknown (25 positives/119 tested)**

Subsequently, having other STDs is an important predictor of becoming HIV infected since STDs are a marker for behaviors associated with HIV transmission.

STD SCREENING FOR FEMALES RECEIVING PREGNANCY TESTS IN REPRODUCTIVE HEALTH FACILITIES

During the time period between October 1, 2003 through March 31, 2004, seventy-one females received urine screening for chlamydia and gonorrhea at the selected six Reproductive Health Facilities across the State. Of the seventy-one females screened, fifty-seven (80%) were between age groups ten years and twenty years.

- Six females (8.4%) were found positive for chlamydia between the age groups fifteen years and twenty-four years. Four of the six cases were found between the age groups ten years and twenty years. Two cases of the six cases were found between the age groups twenty years and twenty- four years.
- The walk-in females requesting pregnancy tests at Nebraska Reproductive Health Clinic are potential high-risk clients regardless of race/ethnicity.
- Of the selected six Reproductive Health Facilities across the State, two are in rural areas (Grand Island and Kearney) and four are in metro areas located in Omaha (Dodge St, Ames St, Northwest, and Southwest Reproductive Care Health Facilities). Four of the chlamydia cases were reported from the rural Reproductive Care Health Facilities.

The overall chlamydia positive rate at the selected six Reproductive Health Facilities across the State for this time period is greater (8.4%) when compared to calendar year 2002 positive chlamydia rates in all Reproductive Health Facilities (5%).

In the initial proposal, four objectives and subsequent outcome measures were established. They are as follows:

Objective #1: By September 30, 2003, forty five hundred women requesting pregnancy tests at Nebraska Reproductive Health Clinics will be screened for chlamydia and gonorrhea.

Outcome Measure #1: Deliver and provide information on testing and provide supplies to screening sites.

Outcome Measure #2: Work with Nebraska Public Health Laboratory and Data Programmer to establish program to monitor.

Outcome Measure #3: Screen eligible women and receive and analyze screening data from the Nebraska Public Health Laboratory.

Objective #2: By September 30, 2003, 203 cases of chlamydia and 68 gonorrhea cases will be diagnosed and treated in women seeking pregnancy testing in Nebraska Reproductive Health Clinics.

Outcome Measure #1: Review data collection systems for chlamydia and gonorrhea positivity rate.

Outcome Measure #2: Find cost benefit of screening using CDC cost benefit formula.

Outcome Measure #3: Ensure proper treatment and interviewing for infected clients.

Objective #3: By September 30, 2003, forty-five hundred women requesting pregnancy tests at Nebraska Reproductive Health Clinics will be educated regarding the prevention of STDs.

Outcome Measure #1: Deliver ongoing/updated STD Treatment Guidelines, STD educational videos, posters, pamphlets, and website information.

Outcome Measure #2: Educate all clients on STDs during exam process.

Objective #4: The quality of at least 95% of specimen submitted will be satisfactory for testing.

Outcome Measure #1: Satisfactory testing of at least 95%.

Outcome Measure #2: Provide feedback quarterly to providers with number of satisfactory specimen to test and the percent of satisfactory specimen to test.

Staff of the STD Program discovered from site and telephone visits at Reproductive Health Facilities that the estimated 13,863 women who received pregnancy tests at Reproductive Health Facilities without being tested for chlamydia and gonorrhea in calendar year 2002 was an over estimation.

The estimated 13,863 for calendar year 2002 data base included both women who received pregnancy tests and new walk-in females who received pregnancy tests at Reproductive Health Facilities without being tested for chlamydia and gonorrhea.

A request was made by the STD Program Administrator to separate the data base and get the estimation for new walking in females who received pregnancy tests at Reproductive Health Facilities without being tested for chlamydia and gonorrhea as soon as possible. We should sample approximately 1,000 urine tests to compare to overall Reproductive Health Facilities positive chlamydia rate.

INDIRECT INDICATORS OF RISK FOR HIV/AIDS INFECTION IN NEBRASKA

Executive Summary

The following measures of risk behavior are available in Nebraska to provide important information on factors that may indirectly affect risk for acquiring or transmitting HIV infection:

- Sexually transmitted disease (STD) rates
- Substance abuse
- Binge drinking
- Unintended pregnancy
- Attitudes towards HIV/AIDS

In addition to data from the Nebraska Health and Human Services System, the 2002 National Survey on Drug use and Health and the Nebraska Behavioral Risk Factor Survey Report 1999-2000 provide information on these risk behaviors and attitudes.

The 2002 National Survey on Drug Use and Health was conducted by the Department of Health and Human Services: Substance Abuse and Mental Health Services Administration - Office of Applied Studies. This data is from an ongoing survey of the civilian, non-institutionalized population of the United States aged 12 years or older. Approximately 68,000 persons were interviewed in 2002. Nebraska estimates are based on data collected in 2002 and was developed using small area estimation procedure data in with Nebraska survey data and were combined with local area county and census block group/tract-level data. For 12-17 year-olds, 756 Nebraskans were selected and 626 responded (weighted interview response rate = 82.80%). For 18-25 year-olds, 759 Nebraskans were selected and 572 responded (weighted interview response rate = 75.22%). For 26+ year-olds, 848 Nebraskans were selected and 628 responded (weighted interview response rate = 74.46%).

The Nebraska Behavioral Risk Factor Survey Report 1999-2000 was conducted by the Nebraska Risk Factor Surveillance System (BRFSS), Nebraska Health and Human Services System. BRFSS has been conducting surveys annually since 1986 in order to collect data on the prevalence of major health risk factors among adults residing in the state. The 1999-2000 report results are based on telephone surveys with 5,921 randomly selected Nebraska residents aged 18 and older.

Survey Results

- Between 1998 and 2002, gonorrhea and chlamydia rates were consistently higher in females compared with males.

- In 2002, illicit drug use was highest among person 18-25 years of age, with 20% reporting that they had used illicit drugs in the past month.

- In 1999, more than one-half of the male respondents aged 18 through 24 (51%) had participated in binge drinking in the past month, compared to 20% of women in this aged group.

- About two-thirds (67%) of Nebraska women aged 18 to 24 who were currently pregnant or had been pregnant within the past five years reported that the pregnancy was unintended (i.e. they wanted to become pregnant later, or they did not want to become pregnant then or at any time in the future).

- The majority of adults aged 18 through 64 (88%) stated that, if they had a sexually active teenager, they would encourage him or her to use a condom.

- When asked to assess their chances of getting infected with HIV, 6% of respondents aged 18-64 years rated their risk as “high” or “medium.”

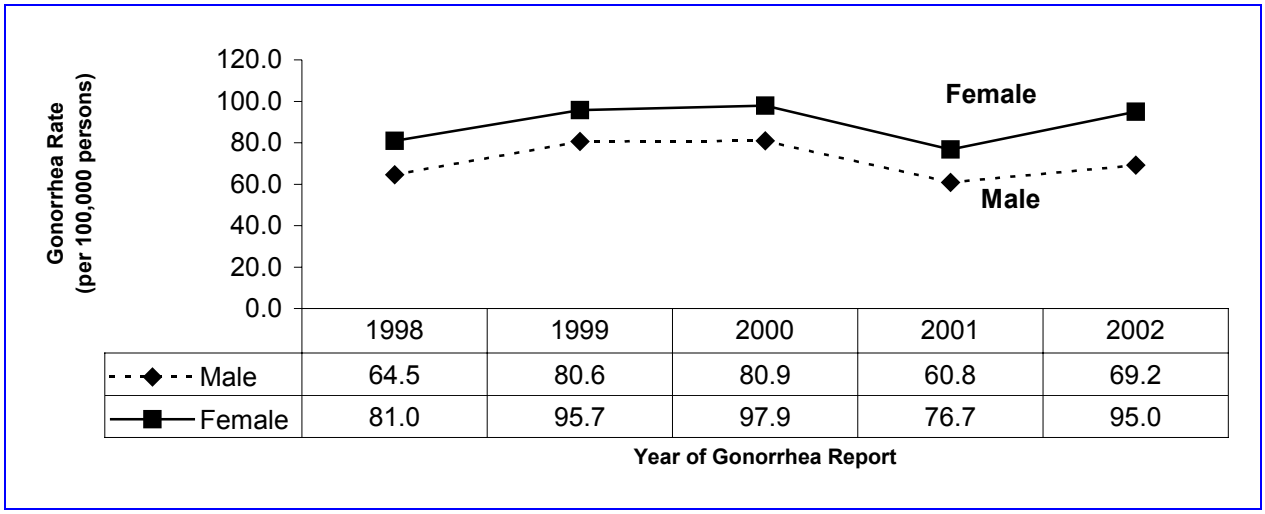
- About one-third of BRFSS respondents aged 18-64 years (34%) said their blood had been tested for HIV infection (excluding tests they may have had as part of blood donations).

STD Surveillance Data

STD Surveillance data provides information that may help identify the potential occurrence of high-risk heterosexual behavior. Although increases in STD rates do not directly indicate that HIV exposure is increasing, these measures may indicate an increase in unprotected sex.

Gonorrhea

Trends in Gonorrhea Rates* by sex, Nebraska, 1998-2002 (N=6,821)



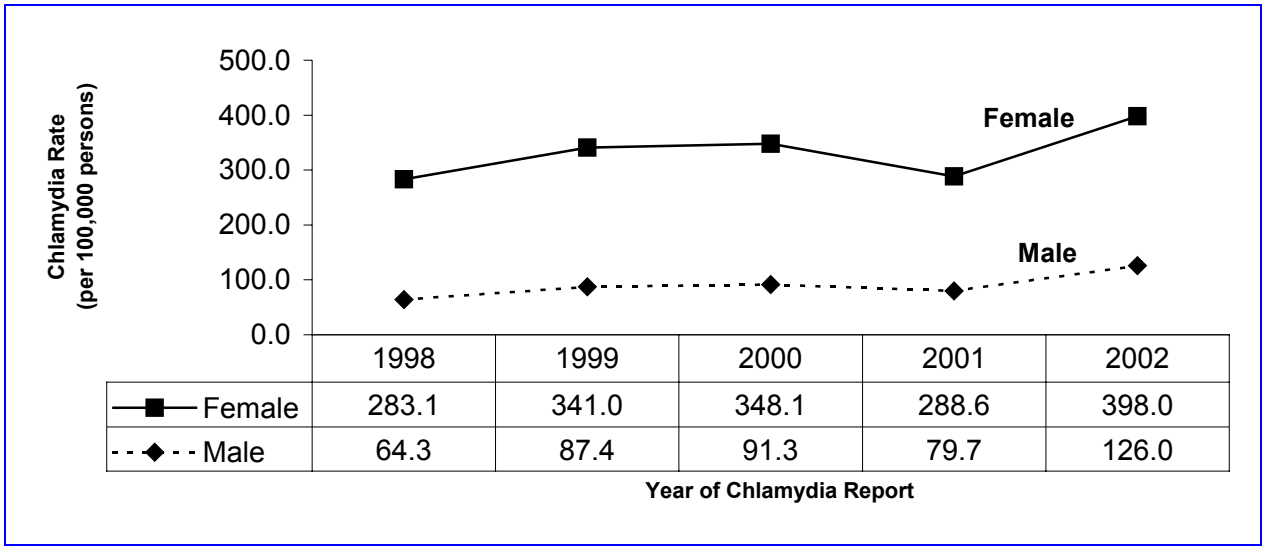
	1998	1999	2000	2001	2002
Male	64.5	80.6	80.9	60.8	69.2
Female	81.0	95.7	97.9	76.7	95.0

Source: Nebraska Health and Human Services System, US Bureau of the Census
*Rates were calculated using the most recent available estimated July 1 population for each year (estimated 3/9/2000 for 1998-1999, and 3/10/2004 for 2000-2003)

Between 1998 and 2002, gonorrhea rates were consistently higher in females compared with males.

Chlamydia

Trends in Chlamydia Rates* by sex, Nebraska, 1998-2002 (N=18,079)



	1998	1999	2000	2001	2002
Female	283.1	341.0	348.1	288.6	398.0
Male	64.3	87.4	91.3	79.7	126.0

Source: Nebraska Health and Human Services System, US Bureau of the Census
*Rates were calculated using the most recent available estimated July 1 population for each year (estimated 3/9/2000 for 1998-1999, and 3/10/2004 for 2000-2003)

Between 1998 and 2002, chlamydia rates were consistently and substantially (3.2-4.4 times) higher in females compared with males.

Substance Abuse Data

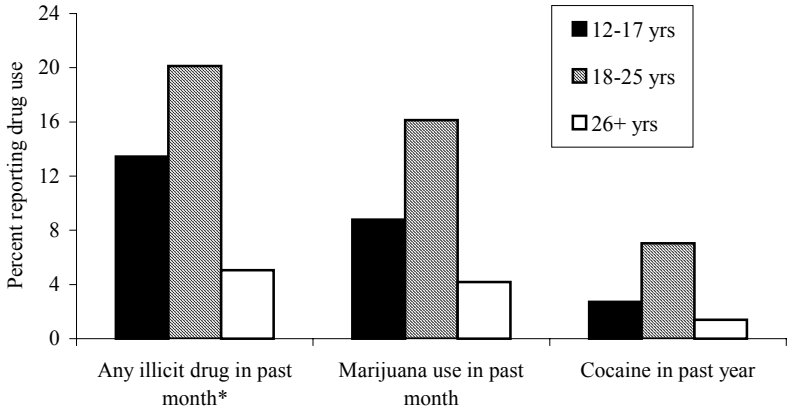
Measures of substance abuse for persons aged 12 years and older, by age, Nebraska, 2001

Measure	Age Group 12-17	18-25	26+	Total
Percentages reporting past month use of any illicit drug*	13.44	20.13	5.05	8.11
Percentages reporting past month use of marijuana	8.79	16.13	4.18	6.38
Percentages reporting past year use of cocaine	2.72	7.04	1.40	2.35
Percentages reporting past year use of alcohol	21.64	65.56	55.63	53.37
Percentages reporting past month binge alcohol use	13.29	48.79	22.92	25.58
Percentages reporting perceptions of great risk of having five or more drinks of an alcoholic beverage once or twice a week	36.97	25.55	43.29	40.07
Percentages reporting past year dependence or abuse for any illicit drug or alcohol	10.90	29.10	7.99	11.32
Percentages reporting needing but not receiving treatment for illicit drug use in the past year	5.41	6.31	1.48	2.60
Average annual rates of first use of marijuana	6.42	5.87	0.02	1.60

Source: 2002 National Survey on Drug use and Health, US Department of Health and Human Services: Substance Abuse and Mental Health Services Administration- Office of Applied Studies

*Illicit drugs included marijuana/hashish, cocaine (including crack), heroin, inhalants, or any prescription-type psychotherapeutic used nonmedically.

Selected measures of substance abuse for persons aged 12 years and older, by age, Nebraska, 2001



Source: 2002 National Survey on Drug use and Health, US Department of Health and Human Services: Substance Abuse and Mental Health Services Administration- Office of Applied Studies

*Illicit drugs included marijuana/hashish, cocaine (including crack), heroin, inhalants, or any prescription-type psychotherapeutic used non-medically.

Among the general population in Nebraska interviewed for the 2002 National Survey on Drug use and Health, eight percent (8%) of persons aged twelve years or older reported using an illicit drug at least once during the past month. Illicit drugs included marijuana/hashish, cocaine (including crack), heroin, inhalants, or any prescription-type psychotherapeutic used non-medically. Regardless of type of illicit drug, drug use was highest among person 18-25 years of age with 20% reporting that they had used illicit drugs in the past month, followed by 20% of the younger age group (12-17 years of age), and 5% the older age group (26+ years).

Binge Drinking

Prevalence of binge drinking by gender and age, education, and income, aged 18 years and older, Nebraska, 1999

	%
Gender and Age	
Male	
18-24	51
25-34	37
35-44	31
45-54	19
55-64	12
65-74	4
75+	3
Female	
18-24	20
25-34	12
35-44	12
45-54	6
55-64	3
65-74	2
75+	1
Education	
Less than HS	14
HS Graduate/GED	16
Some College/Tech	19
College Grad	16
Income	
< $20,000	17
$20,000 - $34,999	17
$35,000 - $49,999	22
$50,000 +	16

Source: Nebraska Health & Human Services System: BRFSS

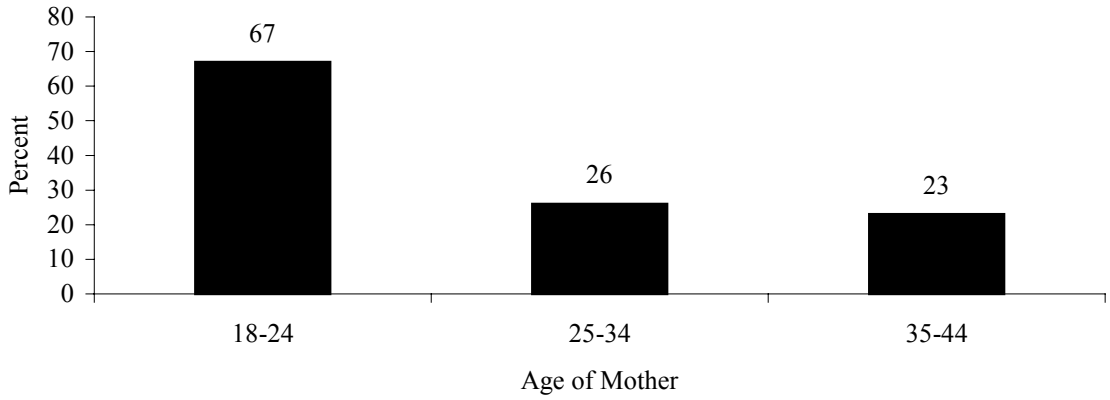
*Five or more drinks of alcohol on at least one occasion during the last month

Among respondents aged 18 and older in 1999, a higher percentage of men than women reported binge drinking, regardless of age group. Young men were much more likely than young women to report binge drinking. More than one-half of the male respondents aged 18 through 24 (51%) had participated in binge drinking in the past month, compared to 20% of women in this aged group.

The proportion of respondents who reported binge drinking was fairly constant across all levels of educational attainment and all income levels.

Unintended Pregnancy

Unintended pregnancy rates by age of mother, Nebraska, 1999-2000



Source: Nebraska Health & Human Services System: BRFSS

Use of birth control for women age 18-44, Nebraska, 1999-2000	
	%
Using birth control	58
Not sexually active	17
Not using birth control because wish to become pregnant	5
Not using birth control and at risk for unintended pregnancy	11
Don't know if using birth control or did not answer	9

Source: Nebraska Health & Human Services System: BRFSS

In 1999-2000, Nebraska women aged 18 to 44 who were currently pregnant or had been pregnant within the past five years were asked how they felt about becoming pregnant just before their last or current pregnancy. Of the respondents, 14% were currently pregnant while the other 86% had a pregnancy occurring during the past five years.

Among those aged 19 to 24 at the time of response, about two-thirds (67%) responded that the pregnancy was unintended (i.e. they wanted

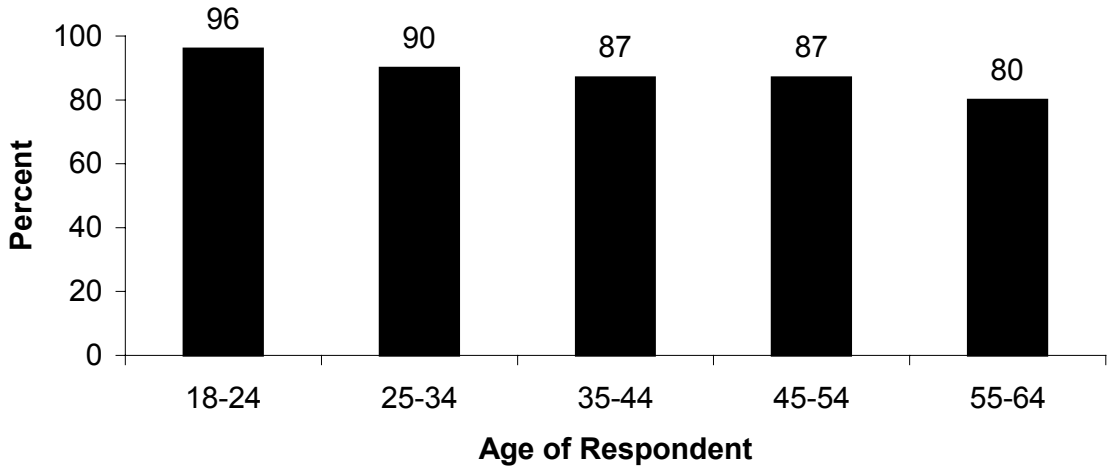
to become pregnant later, or they did not want to become pregnant then or at any time in the future). Among the two older age groups of mothers, the proportion reporting unintended pregnancy was lower (26% of those aged 25-34; 23% of those aged 35-44).

Women aged 18-44 in the 1999-2000 BRFSS were asked whether or not they or their partner were using any kind of birth control at the time of the survey. Birth control was defined for them as "having your tubes tied, vasectomy, the pill, condoms, diaphragm, foam, rhythm, Norplant, shots (Depo-Provera) or any other way to keep from getting pregnant."

Nearly six of every ten respondents in this age group (58%) said they were currently using a form of birth control, while 17% reported that they were not sexually active. Five percent were not using a birth control method because they were attempting to become pregnant. Eleven percent of the women asked this question were not using birth control for various other reasons. Nine percent of respondents didn't know if they were using birth control or didn't answer the question. Of the women who reported that they or their partner were currently using birth control, 14% of respondents reported using condoms to prevent pregnancy.

Attitudes Toward HIV/AIDS

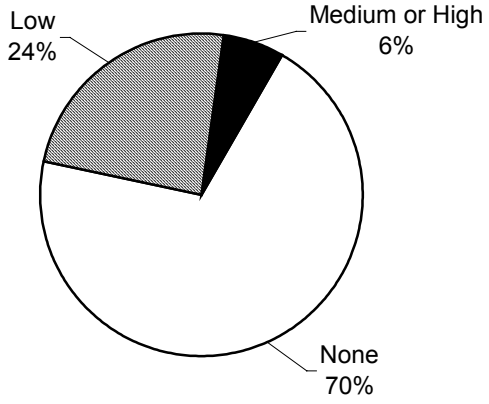
Percentages of respondents who would encourage a sexually active teen to use condoms, aged 18-64, Nebraska, 1999-2000



Source: Nebraska Health & Human Services System: BRFSS

The majority of adults aged 18 through 64 (88%) stated that, if they had a sexually active teenager, they would encourage him or her to use a condom. The proportion of respondents who would actively encourage this practice for sexually active adolescents was highest among young adults. Among 18-24 year-olds, 96% indicated support for this concept, as did 90 of respondents in the 25-34 age group. Respondents in the middle age groups (35-54) were somewhat less likely to do so (87%). Among those aged 55-64, 80% said they would recommend condom use in these situations.

Perceived chances of getting HIV, aged 18-64, Nebraska, 1999-2000



Source: Nebraska Health & Human Services System: BRFSS

When asked to assess their chances of getting infected with HIV, 6% of respondents aged 18-64 years rated their risk as “high” or “medium.” About one-fourth (24%) stated their chances of contracting HIV were “low.” The greatest proportion of respondents (70%) said there was no chance of them getting infected with HIV. The proportion of respondents who rated their risk of contracting HIV as “high” or “medium” was fairly constant across all age groups, all levels of educational attainment and all income levels.

Percieved Chances of Getting HIV by age, education, and income, aged 18-64, Nebraska, 1999-2000

	Precieved chances of getting HIV (%)			
	High	Medium	Low	None
Age				
18-24	2	6	32	60
25-34	1	6	29	64
35-44	1	4	24	71
45-54	1	3	19	77
55-64	1	4	14	81
Education				
Less than HS	1	4	21	74
HS Graduate/GED	2	4	20	74
Some College/Tech	1	6	27	66
College Grad	1	4	26	70
Income				
< $20,000	2	5	30	63
$20,000 - $34,999	1	5	24	70
$35,000 - $49,999	2	4	25	69
$50,000 +	1	4	22	73

Source: Nebraska Health & Human Services System: BRFSS

Percentages who have ever had their blood tested for HIV by age, perceived risk of getting HIV, and gender, aged 18-64, Nebraska, 1999-2000

	%
Age	
18-24	32
25-34	50
35-44	38
45-54	27
55-64	21
Perceived risk	
High or Medium	41
Low	40
None	31
Gender	
Male	35
Female	33

Source: Nebraska Health & Human Services System: BRFSS

About one-third of BRFSS respondents aged 18-64 years (34%) said their blood had been tested for HIV infection (excluding tests they may have had as part of blood donations). Men and women were about equally likely to have had their blood tested for this infection (35% and 33%, respectively). One-half of young adult respondents aged 25-34 had been tested for HIV. The proportion that had been tested was lowest among respondents aged 45 and older. The proportion of respondents who reported being tested for HIV was 41% among those who felt

they were at “high” or “medium” risk of becoming infected with the virus and 40% among those who felt they were at “low” risk. Among respondents who stated there was no risk of them becoming infected with HIV, 31% indicated that they had been tested.

Main reason for most recent HIV blood test, aged 18-64, Nebraska, 1999-2000

Reason	%
Routine Reasons	
Pregnancy	6
Routine checkup	13
Life insurance	10
Military	9
Hospital/surgical procedure	7
Health insurance	6
Employment	5
Blood donation	1
Marriage	<1
Immigration	<1
Subtotal	68
Perceived Risk Reasons	
For own information	16
Occupational exposure	4
Illness	3
HIV risk	1
Referral by physician	<1
Referral by sex partner	<1
Subtotal	25
Other Reasons	
Other	6
Don't know	<1
Refused	<1
Subtotal	7

Source: Nebraska Health & Human Services System: BRFSS

Reasons for having blood tested for HIV infection varied, but two-thirds (68%) of those tested stated that the HIV test was done as a routine requirement of some kind (e.g. pregnancy exam, routine checkup, life insurance checkup, etc.). One fourth (25%) of respondents who had been tested cited reasons that may indicate that the respondent felt he or she was at increased risk for contracting HIV (e.g. for own information, occupational exposure, illness, etc.).